

Doctor's Order Sheet

**talazoparib 0.5 mg -
enzalutamide 160 mg -
Regimen**

ARIA Protocol Name: talazoparib 0.5 mg enzalutamide 160 mg - Compassionate
Adult Chemotherapy - Medical Oncology
Metastatic Castration Resistant Prostate Cancer



CC9170 0637 01 2026

Name: _____

HCN: _____

Date of Birth: _____

Weight: _____ kg Height: _____ cm Body Surface Area (BSA) = _____

Allergies:

No Known

Date: DD/MONTH/YYYY Planned Administration Date: DD/MONTH/YYYY

Cycle of **Cycle Duration: 28 days** Date of previous cycle: DD/MONTH/YYYY

MAY PROCEED WITH DOSES AS WRITTEN IF:

- ANC **greater than or equal to** 1 X 10⁹/L, platelets **greater than or equal to** 50 X 10⁹/L and hemoglobin **greater than or equal to** 80 G/L, otherwise notify Medical Oncologist.
- Creatinine clearance assessed.
- Blood pressure assessed.
- PSA assessed.

PREMEDICATIONS: None recommended

Other: _____

CHEMOTHERAPY (FOR COMMUNITY PHARMACY):

- talazoparib 0.5 mg PO daily**
 - Dose modification: **talazoparib 0.35 mg PO daily**
 - Dose modification: **talazoparib 0.25 mg PO daily**
 - Dose modification: **talazoparib 0.1 mg PO daily**
- enzalutamide 160 mg PO daily**
 - Dose modification: **enzalutamide 120 mg PO daily**
 - Dose modification: **enzalutamide 80 mg PO daily**

PLEASE REFER TO CHEMOTHERAPY LETTER WHEN ORDERING SUPPORTIVE MEDICATIONS FOR THIS PATIENT

Authorized Prescriber: _____ Date: DD/MONTH/YYYY Time: _____

Authorized Prescriber's Signature: _____ ID #: _____

Nurse's Name: _____ Date: DD/MONTH/YYYY Time: _____

Nurse's Signature: _____

THIS IS A CONTROLLED DOCUMENT. PLEASE ENSURE THAT YOU ARE READING THE MOST RECENT VERSION.